FRVS per Section V.E.1.a.- g. of this plan, solely due to the execution of a lease agreement between related organizations under Section III.F. of this plan.

(2) In no case shall Medicaid reimburse property costs of a provider who is subject to b., c., and d. (1) above and e. below if ownership costs are not properly documented per the provisions of this plan. Providers shall not be reimbursed for property costs if proper documentation, capable of being verified by an auditor, of the owner's costs is not submitted to AHCA. The owner shall be required to sign a letter to AHCA that states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the nursing home properties available to auditors or official representatives of AHCA.

(3) Approval shall not be given for a proof of financial ability for a provider if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (2) above.

e. A lease agreement may be assigned and transferred (assumed) for Medicaid reimbursement purposes if all of the following criteria are met:

(1) The lease agreement was executed prior to September 1, 1984 (when the "limitations of rents" provisions were implemented).

(2) The lease cost is allowable for Medicaid reimbursement purposes.

(3) The lease agreement includes provisions that allow for the assignment.

(4) All provisions (terms, payment rates, etc.) of the lease agreement remained unchanged (only the lessee changes).

When the assumed lease contract in effect on September 30, 1985, expires, including only options to renew which were exercised prior to October 1, 1985, reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per Section V.E.1.a.-g. of this plan.

3. Basis for depreciation and calculation:

a. Cost.

Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by 3b. and 6. below. All provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS-PUB.15-1 (1993) regarding asset cost finding shall be followed.

b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties: purchase the depreciable assets of the facility; or purchase 100 percent of the stock of the facility and within 1 year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In a case in which a change in ownership of a provider's or the lessor's depreciable assets occurs, and if a bona fide sale is established, the basis for depreciation shall be the lower of:

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1) The fair market value of the depreciable facility as defined by 42 CFR 413.134 (2000) and determined by an appraiser who meets the requirements of Section 59A-4.103 (6) (I) 9. b. Florida Administrative Code;

2) The allowable acquisition cost of the assets to the owner of record on July 18, 1984, for facilities operating on that date, or the first owner of record for facilities that begin operation after July 18, 1984; or

3) The acquisition cost of such assets to the new owner.

Example 1: An owner, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $500,000.00. A new owner purchases the facility for $1,000,000.00. The new owner's basis for depreciation is the lesser of the two, or $500,000.00.

Example 2: An owner, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $500,000.00. A new owner purchases the facility for $300,000.00. The new owner's basis for depreciation is the lesser of the two, or $300,000.00.

4. Limitation on interest expense for property-related debt and on return on equity or use allowance. At a change of ownership on or after July 18, 1984, the interest cost and return on equity or use allowance to the new owner shall be limited by the allowable basis for depreciation as defined per 3.b. above. The new owner shall be allowed the lesser of actual costs or interest cost and return on equity cost or use allowance in amounts that would have occurred based on

the allowable depreciable basis of the assets. These limited amounts shall be determined as follows:

a. The portion of the equity balance that represents the owner's investment in the capital assets shall be limited for purposes of calculating a return on equity or use allowance to the total amount allowed as depreciable basis for those assets as per 3.b. above.

b. The amount of interest cost due to debt financing of the capital assets shall be limited to the amount calculated on the remainder of the allowable depreciable basis after reducing that allowable basis by the amount allowed for equity in a. above. The new owner's current terms of financing shall be used for purposes of this provision.

   Example 1: The first owner of record after July 18, 1984 has an acquisition cost of $600,000.00. The new owner pays $1,000,000.00 for the facility, makes a down payment of $200,000.00 and finances $800,000.00 at 15 percent for 25 years. The basis for depreciation to the new owner is $600,000.00, and the disallowed portion of the depreciable basis is $400,000.00. Therefore, the allowable equity attributable to investment in the capital assets is $200,000.00, and interest cost allowed shall be computed on $400,000.00 ($600,000.00 minus $200,000.00) at 15 percent over 25 years.

   Example 2: If the new owner above had made a down payment of $700,000.00 and financed $300,000.00, the allowable equity would be $600,000.00, and no interest cost would be allowed.

5. Costs attributable to the negotiation or settlement of a sale or purchase of a facility occurring on or after July 18, 1984 shall not be considered allowable

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costs for Medicaid reimbursement purposes to the extent that such costs were previously reimbursed for that facility under a former owner. Such costs include legal fees, accounting fees, administrative costs, travel costs, and costs of feasibility studies, but do not include costs of tangible assets, financing costs, or other soft costs.

6. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991.

	Example 1	**Example 2**
New Facility Cost	$3.0 Million	$4.0 Million
CON Approval	$2.8 Million	$3.0 Million
Medicaid Allowable Cost	$2.5 Million	$3.5 Million
Reimbursable Cost	$2.5 Million	$3.0 Million

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

H. Recapture of depreciation resulting from sale of assets.

1. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement, indicates

the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture applicable to payments made to facilities prior to reimbursement under the FRVS shall be determined as follows:

(a) The gross recapture amount shall be the lesser of the actual gain on the sale allocated to the periods during which depreciation was paid or the accumulated depreciation after the effective date of January 1, 1972 and prior to the implementation of payments based on FRVS to the facility. The gross recapture shall be reduced by 1.00 percent for each month in excess of 48 months' participation in the Medicaid program. Additional beds and other related depreciable assets put into service after April 1, 1983 shall be subject to the same 12 1/3 year depreciation recapture phaseout schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by 1.00 percent for each month in excess of 48 months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the proportion of beds in that part of the facility by the sales price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sale Price: $6,000,000
Older Portion of facility:
Number of beds = 60

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Newer portion of facility:
Number of beds = 120

Allocation to older portion:	(60/180) x 6,000,000 =	$2,000,000
Allocation to new portion:	(120/180) x 6,000,000 =	$4,000,000
Sale Price		$6,000,000

(b) The adjusted gross recapture amounts as determined in (a) above shall be allocated for fiscal periods from January 1, 1972, through the earlier of the date of sale, or the implementation of payments based on the FRVS for the facility. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(c) The net recapture overpayment amount, if any, so determined in (b) above shall be paid by the former owners to the State. If the net recapture amount is not paid by the former owner, in total or part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

2. Depreciation recapture resulting from leasing facility or withdrawing from Medicaid program. In cases where an owner-operator withdraws from the Medicaid program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the time he was the Medicaid provider

shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated, licensed operator after having operated the facility as a licensed Medicaid provider. After April 1, 1983, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the Agency creating an equitable lien on the owner's nursing home assets. This lien shall be filed by the Agency with the clerk of the Circuit Court in the Judicial Circuit within which the nursing home is located. The contract shall specify the method for computing depreciation recapture, in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the Agency upon sale of the facility. In the event that an owner-provider withdraws from the Medicaid program, the reduction in the gross depreciation recapture amount calculated in Section III. H.1. (a) above shall be computed using only the number of consecutive months that the facility is used to serve Medicaid recipients. EXAMPLE: An owner-operator participates in Medicaid for 60 months. He then withdraws from the Medicaid program and leases the facility to a new operator, who enters the Medicaid program as a new provider and participates for 24 months. At the end of the 24 months, the lessee withdraws from the Medicaid program and operates the facility for another 5 years, after which the owner sells the facility. The gross recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Medicaid during the 60 months that he was the provider. The reduction in the gross recapture amount will be (60+24 - 48) months times 1.00 percent. If a provider fails to sign and return the contract to the Agency, the new license for the prospective operator of the facility shall not be approved.

I. Recapture of property cost indexing above the FRVS base paid under the fair rental value method.

1. Reimbursement due to indexing paid under the FRVS shall be defined as the accumulated reimbursement paid due to the difference between the FRVS rates paid and the initial FRVS rate established for the facility.

2. Upon sale of assets recapture of reimbursement due to indexing under FRVS shall be determined as follows:

    (a) The total amount of indexing shall be recaptured if the facility is sold during the first 60 months that the facility has been reimbursed under FRVS;

    (b) For months 61 and subsequent, 1 percent of the recapture amount shall be forgiven per month. Two percent of the recapture amount shall be forgiven per month if the facility had Medicaid utilization greater than 55 percent for a majority of the months that the facility was reimbursed under FRVS; and

3. Documented costs of replacement equipment purchased subsequent to FRVS payments and for which additional payments were not made per Section V.E.1.j. shall reduce dollar-for-dollar the amount of recapture, but shall not create a credit balance due to the provider.

J. Return on Equity.

A reasonable return on equity (ROE) for capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of this plan as an allowable cost. This return on equity shall use the principles stated in Chapter 12, CMS-PUB.15-1 (1993) except that the rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the Medicaid Program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis. For facilities being reimbursed under FRVS for property, positive equity in capital assets shall be removed from the owners' equity balance in computing ROE. A full return on equity payment shall be calculated on 20 percent of the FRVS asset valuation per Section V.E. 1.e. of this plan and included in the FRVS rate.

K. Use Allowance.

A use allowance on equity capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of the plan as an allowable cost. The use allowance shall be allowed for non-profit providers except those that are owned or operated by government agencies. This use allowance shall use the principles stated in Chapter 12, CMS-PUB.15-1 (1993) established in Section J. above, but shall be limited to one-third of the rate given to profit-making providers. For facilities being reimbursed under the FRVS method for property costs, including governmentally owned or operated facilities, all provisions of J. above, including the full rate of return, shall be used in computing the use allowance for the property-related equity and included in the FRVS rate.

L. Legal Fees and Related Costs.

In order to be considered an allowable cost of a provider in the Florida Medicaid Program, attorneys' fees, accountants' fees, consultants' fees, experts' fees and all other

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fees or costs incurred related to litigation, must have been incurred by a provider who was the successful party in the case on all claims, issues, rights, and causes of action in a judicial or administrative proceeding. If a provider prevails on some but less than all claims, issues, rights, and causes of action, the provider shall not be considered the successful party and all costs of the case shall be unallowable. All costs incurred on appellate review are governed in the same manner as costs in the lower tribunal. If, on appeal, a provider prevails on all claims, issues, rights and causes of action, the provider is entitled to its litigation costs, in both the lower tribunal and the reviewing court, related to those claims issues, rights and causes of action in which a provider is the successful party on appeal, as determined by a final non-appealable disposition of the case in a provider's favor. This provision applies to litigation between a provider and AHCA, relating to Medicaid audits, Medicaid cost reimbursement cases, including administrative rules, administrative rules affecting Medicaid policy, and certificate of need cases. This provision pertains only to allowable costs for the recalculation of reimbursement rates and does not create an independent right to recovery of litigation costs and fees.

M. Effective January 1, 2002, the direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. Direct care staff does not include nursing administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

N. Effective January 1, 2002, all other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company for staff who do not deliver care directly to residents in the nursing home facility.

Providers on budget at the January 1, 2002 rate setting will not be required to submit a supplemental schedule. The Agency for Health Care Administration will divide the interim patient care costs into direct and indirect subcomponents based on a 65% and 35% split, respectively. The patient care split will be subject to settlement upon receipt of their initial cost report.

IV. Standards

A. In accordance with Section 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall also be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. For purposes of establishing reimbursement ceilings, each nursing home within the State shall be classified into one of six reimbursement classes as defined in V. A.3 of this plan. Separate reimbursement ceilings shall be established for each class. Separate operating and patient care reimbursement ceilings shall be established for each class, but the property cost component shall be subject to a statewide reimbursement ceiling for facilities still being reimbursed depreciation and interest per Section III.G. 3.-5.

C. The ceilings shall be determined prospectively and shall be effective semiannually, on January 1 and July 1. The most current cost reports postmarked or accepted by a common carrier by October 31 and April 30 and received by November 15 and May 15, respectively, shall be used to establish the operating and patient care class ceilings. Beginning with the January 1, 1988, rate period additional ceilings based on the Target Rate System shall also be imposed. Beginning with the July 1, 1991 rate period, additional ceilings for new providers shall also be imposed. The first cost report

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submissions for all newly constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end of these newly constructed facilities shall be after October 1, 1977. In addition, all facilities with year ends prior to that of the one hundredth facility in an array from most current to least current year end shall not be considered in setting the property cost ceilings. Ceilings shall be set at a level, which the State determines to be adequate to reimburse the allowable and reasonable costs of an economically and efficiently operated facility. The property ceiling for facilities being reimbursed per Section III.G.3.-5. of this plan pending transition to payments based on the FRVS shall be the ceiling in effect at July 1, 1985. The operating and patient care class ceilings shall be the maximum amount paid to any provider in that class as reimbursement for operating and patient care costs. Establishment of prospective class ceilings and an individual provider's reimbursement rate will reasonably take into account economic conditions and trends during the time periods covered by the payment rates. A provider shall be exempt from the operating and patient care class ceilings and target rate ceilings if all of the following criteria are satisfied:

a) All of the resident population are dually diagnosed with medical and psychiatric conditions.

b) No less than 90 percent of the resident population suffers from at least one of the following: severe behavioral, emotional, or cognitive difficulties resulting from their psychiatric impairment.

c) The facility provides clinically appropriate care to address these behavioral, cognitive, and emotional deficits.

d) A medically approved individual treatment plan is developed and implemented for each patient. The plan comprehensively addresses the client's medical, psychiatric, and psychosocial needs.

e) The facility complies with the licensure provisions for specialty psychiatric hospitals in accordance with Rule 59A-3 FAC.

f) The facility complies with HRSR 95-3 with regard to psychotropic drugs or establish written facility standards that meet or exceed this regulation.

g) The facility complies with HRSM 180-1 with regard to quality assurance procedures or establishes written facility standards that meet or exceed this regulation.

Beginning on or after January 1, 1984, provider whose reimbursement rates are limited to the class ceiling for operating and patient care costs shall have their reimbursement exceeded under the circumstances described below. The provider must demonstrate to the Agency that unique medical care requirements exist which requires extraordinary outlays of funds causing the provider to exceed the class ceilings. Circumstances which shall require such an outlay of funds causing a provider to exceed the class ceilings as referenced above shall be limited to:

a) Acquired Immune Deficiency Syndrome (AIDS) diagnosed patients requiring isolation care;

b) Medically fragile patients under age 21 who require skilled nursing care.

The period of reimbursement in excess of the class ceilings shall not exceed 6 months. A flat rate shall be paid for the specific patients identified, in addition to the average per diem paid to the facility. The flat rate amount for AIDS patients shall include the costs of incremental staffing and isolation supplies, and shall be trended forward each rate semester using the DRI indices used to compute the operating and patient care ceilings. The flat rate payment for Medically fragile patients under age 21 who require skilled nursing care shall be the same as the flat rate payment ~~for "grandfathered in" ventilator~~

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patients, and shall be trended forward using the DRI indices in the same manner as the payment for AIDS patients. Patients requiring the use of a ventilator and related equipment whose costs were approved under the 10/1/85 reimbursement plan shall be "grandfathered in"--that is, a flat rate shall be paid for incremental staffing costs only. Costs of the ventilator and related equipment, that is, rent, depreciation, interest, insurance and property taxes, shall be paid in addition to the flat rate. No new ventilator patients shall be approved for payment above the ceilings as of the effective date of this plan. Ventilator patients that have their Medicaid eligibility canceled and later reinstated will no longer be "grandfathered in." Instead, they are considered to be new ventilator patients. These incremental costs shall be included in the cost reports submitted to AHCA, but shall not be included in the calculation of future prospective rates. The incremental costs of staffing and isolation supplies for AIDS patients, incremental costs of staffing for ventilator patients, and the cost of Medically fragile patients under age 21 who require skilled nursing care, shall be adjusted out based upon the flat rate payments made to the facility, in lieu of separately identifying actual costs. The cost of ventilators and related equipment shall be adjusted out based upon payments made to the facility, in lieu of separately identifying actual costs. Special billing procedures shall be obtained by the provider from the Medicaid Office of Program Development. The class ceilings may also be exceeded in cases where Medicaid patients are placed by the Agency for Health Care Administration in hospitals or in non-Medicaid participating institutions on a temporary basis pending relocation to participating nursing homes, for example, upon closure of a participating nursing home. The CMS Regional Office shall be notified in writing at least 10 days in advance in all situations to which this exception is to be applied, and shall be advised of the rationale for the decision, the financial impact, including the proposed rates, and the number of facilities and patients involved. AHCA

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